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ABSTRACT

This module, one of six on teaching consumer matters to low-income groups, focuses on health care alternatives. It provides helpers of low-income people in Virginia with a composite of information in the areas of traditional health care, alternatives to the traditional methods, insurance, medications, and fraudulent practices. At the end of each unit, tools for teaching and teaching techniques which can be utilized to convey this information to clients are included. Appended materials include information about nursing homes, social service agencies, medicare, and questions to ask the doctor. (CT)

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A HEALTH CARE PLANNER

TEACHING LOW-INCOME CONSUMERS ABOUT HEALTH CARE ALTERNATIVES

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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I. INTRODUCTION

Health care is a consumer commodity; the product is a person's well being. Unfortunately, the cost of good health care is becoming increasingly prohibitive, even to those people who earn an adequate salary. For low-income people, it is becoming an unaffordable luxury.

Alternatives to the traditional doctor/hospital/insurance method have been developed that can be cost effective and still serve patients quite adequately. In addition, preventive health techniques can reduce the number of times an individual needs to seek medical attention, thereby reducing the cost of his/her health care even further.

Because "the best consumer is an informed consumer" it is the purpose of this booklet to provide helpers of low-income people in Virginia with a composite of information on health care in the areas of traditional health care, alternatives to the traditional methods, insurance, medications and fraudulent practices. At the end of each unit, we have also included some tools for teaching and teaching techniques which can be utilized to convey this information to clients.

The reader should be aware that not all of the alternatives will be available to all clients. Medicaid recipients will qualify for one type of service, while those clients whose income is low, but not low enough to qualify for Medicaid might be able to utilize another service. It is up to the provider to investigate with the client the best resources available to him/her. This booklet is to be used as a tool in teaching low-income or elderly consumers appropriate health care and the resources available in Virginia. It is also meant to provide helpers of the above groups with information in the health care field.

II. PROPER HEALTH CARE

In teaching low-income people cost-effective health care, begin and end your training with a discussion of proper health care. The best way to avoid the high cost of health care is to be in control of one's health habits. Medical progress has allowed us, now as never before, to be in control of our health. Because of early immunization programs, we can expect to be free of the illnesses of childhood which were often crippling or even fatal. Now, with proper rest, diet and exercise people can look forward to long, vigorous lives.

Unfortunately, there are still people who leave health to chance. They risk losing their newborns because of improper prenatal care, they lose their children to disease because they fail to get them properly immunized and they risk their own lives and their children's adult lives by failing to provide proper nutrition.

Women should seek a doctor's care as soon as they suspect that they are pregnant. More babies with birth defects are born to mothers who were on drugs or alcohol, who smoked, or who did not eat properly during their pregnancies than to those mothers who avoided the use of drugs, cigarettes and alcohol and who ate properly. Obese mothers have a tendency to have underweight babies and difficult deliveries. An infant can be given a fair chance to survive if a mother cares for it from the moment of conception.

People do not have to be rich to give their children adequate nutrition and health care. Immunizations for children are given at no cost through the Health Department or Community Clinic. Parents are becoming increasingly negligent, however, in this area, perhaps because they have forgotten or have never seen a child who has died from or suffered the effects of polio, measles, or diptheria.

A child does not need to be raised on a diet of steak and potatoes. Children can receive adequate nutrition from eggs, peanut butter, vegetables, fruit, and powdered milk as a substitute for meat dishes. What should be avoided are those foods that add calories, deprive a child of good nutrition, and explode the grocery budget - foods such as soda, candy, potato chips, ice cream, cake, etc. Children should also get plenty of exercise and rest. Countless hours spent watching television deprives them of the elements of a healthy childhood.

Children who are given proper nutrition, adequate rest and exercise, and all of their immunizations are being taught good

health care, a legacy they can carry through their adulthood and leave to their children and grandchildren.

It is important for adults to follow the rules of good nutrition, rest and exercise. The diseases or difficulties adults suffer from, such as late-onset diabetes, high blood pressure, arthritis, cancer and cardio-vascular problems, are often the result of poor diet, lack of exercise or abuse.

Adults would do well to examine their habits and, in some cases, do without. Smoking probably heads the list. It costs a fortune to maintain the habit and a fortune to care for the results: emphysema, chronic bronchitis, throat and lung cancer, and heart disease.

Overeating leads to chronic obesity, high blood pressure and heart disease, and aggrevates arthritis. As people get older their metabolism changes; they need fewer calories to maintain their weight. Therefore, they need to reduce their caloric intake while still maintaining their basic nutrients. It's best to minimize or eliminate those foods which are high in cholesterol and sugar, and to be sure to get enough protein, calcium, and fiber in one's diet.

The abuse of over-the-counter drugs or alcohol can also lead to health problems. Drugs should be taken only as necessary for pain or fever. Anything stronger than aspirin should probably be prescribed by a physician. While alcohol has been found to be beneficial when taken in limited quantities, abuse leads to many problems. Moderation should be the key word for alcohol consumption.

As people get older, the kinds of exercise and the amount they get changes. It is advisable for an adult to exercise at least three times a week; however, he should check with his physician before indulging in any vigorous exercise activity.

If a person watches his diet, gets adequate rest and exercise and eliminates smoking, drugs, and excessive alcohol consumption from his life, the number of times he needs to seek medical attention will not be very frequent. However, he should also be aware of the early signs of disease and should seek a doctor's attention as soon as a problem is suspected. Early disease detection is an important factor in reducing an individual's health care costs.

TEACHING TECHNIQUE

GOAL: To have people incorporate into their life style the fundamentals of preventive health care.

OBJECTIVES: 1. To provide clients with information about good nutrition and its effect on the body.

2. To inform clients about the necessity of adequate rest and exercise.

3. To provide clients with information on early disease detection.

4. To provide clients with resources to assist them in modifying or improving their health habits.

STRATEGIES: Small group work

1. Provide clients with a list of foods, which vary in cost, from each of the seven food groups. Have clients derive menus which are low in cost and nutritious. For homework, have them prepare these menus for their families. Invite a dietician to join the group for some "expert" advice.

2. Invite a physician to give a lecture on preventive health techniques. Have the clients prepare some questions for him in advance.

3. Invite someone from the local Heart Association, Lung Association, or Cancer Society to provide a "Quit Smoking" clinic. Also ask for literature on early disease detection, proper health care, etc.

4. Brainstorm ideas for exercise programs, e.g. half-hour walks, exercise programs in the community hall, cordoning off a dead-end street for tag, street hockey, etc. and help to impliment those ideas which the group finds most useful.

TECHNIQUES TO KEEP IN MIND WHEN TEACHING ADULTS:

1. Keep each session light and lively.
2. Utilize the adult's experience and make it relevant to the subject you are teaching.
3. Use short, attainable objectives.
4. Evaluate each session: how will clients use the information that they've learned today?
5. Help clients to see alternatives to the way they do things now.
6. Remember that often the process of teaching is more important than the content of what you want to teach. If the subject matter is presented effectively, clients will seek additional information on their own.

Proper health care also involves routine visits to the doctor, and occasionally, a stay in the hospital for the treatment of a health problem. In the following pages we will investigate the various ways these expenses can be handled. We will begin with the traditional methods of health care, that is the physician, hospital and method of payment or insurance. Following that discussion we will examine the alternatives to that traditional care.

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III THE TRADITIONAL METHODS OF TREATMENT

A. THE FEE-FOR-SERVICE PHYSICIAN

When one thinks of health care, a person automatically thinks of the traditional, fee-for-service physician. A fee--for-service physician is one who is paid by each patient that he sees according to a fee schedule for each service provided. For instance, he might charge $35.00 for a yearly examination, $25.00 for X-Rays, and $25.00 for routine lab work, etc. If a patient had a set of X-Rays and some blood drawn during his yearly physical, his bill would total $85.00. The payment of the bill can be covered by Medicare, Medicaid, private health insurance, or the patient's own funds.

The physician one generally sees for all routine care is a *primary care physician*, such as a general practitioner, family practitioner, internist, pediatrician, or, in the case of many women, an obstetrician/gynocologist. This is the physician people see first when they have a health problem or when they go for a routine check-up.

If the primary care physician detects a problem that will need specialized treatment, such as a heart ailment, urinary tract problem, or neurological problem, s/he will refer the patient to a secondary care physician such as a cardiologist, urologist, or neurologist. The primary care physician is the doctor a person would want to choose first for all routine work or if one suspects there is a problem. He can do the initial screening, perhaps diagnose and even cure the problem without sending the patient to a secondary care physician or specialist. Primary care treatment is generally much less expensive that specialized treatment.

There are ways to choose a primary care physician and ways not to. One should NOT choose a physician from the yellow pages of the phone book - many good physicians are not even listed there.

The best way to choose a physician is to first contact the nearest medical school or teaching hospital and ask for a list of the doctors that they have on staff. Doctors at medical schools or teaching hospitals are generally current in new medical techniques and are good because of the constant association with other physicians. Ask a professor there who he recommends or uses as his physician. Doctors are good judges of other physicians.

If a medical school or teaching hospital is not close by, then one should contact the nearest certified hospital and ask for a list of the physicians who are affiliated with them. Another method would be to check with the Health Systems Agency in an individual's jurisdiction. Some Health Systems Agencies have published a physicians directory. Choose a primary care physician who is board certified. Then contact the physician. Ask him or his nurse about his policies and background.

1) How many years of residency did he have beyond medical school? A general practitioner can practice without any residency experience. However, a family practitioner, pediatrician, internist, and gynocologist all need at least two years of residency..

2) In what hospital did he do his residency? Was it certified?

3) Does he have a medical society membership?

4) How long does it take to get an appointment?

5) How are payments handled?

6) Does he accept Medicare, Medicaid, or other health insurance payments?

7) Does he have a group or solo practice?

Once a person screens a physician on the basis of the above questions, s/he should make an appointment and judge for oneself if the physician is the type of person who takes the time to answer all of the patient's questions adequately. Does the doctor understand the problem and does the patient feel good about the way s/he is treated? Does the doctor examine the patient thoroughly and, on the first visit, take the time to get to know the patient and develop a good medical history by asking questions relevant to the patient's past, family status,

and life-style? Above all, the patient should feel comfortable with his physician. The choice of a doctor is an individual matter. The kind of doctor a person chooses depends on the kind of person s/he is, the kind of attention s/he is looking for, and how the doctor provides it.

The alternatives to the traditional fee-for-service physician are Health Maintenance Organizations and outpatient clinics which will be discussed later in the booklet.

SECOND OPINIONS Under Medicare, patients are entitled to obtain a second opinion for prescribed surgery. A second opinion is a way of getting additional information from an objective source. A person's doctor should not be offended if s/he suggests one. In fact, once a person has received another opinion, he'll know what treatment is best for him. If there seems to be a conflict, s/he can check back with his physician or seek a third opinion. However, one should NOT keep checking around for the option he wants to hear. Postponing medical care is not the purpose of seeking a second opinion. Medicare will pay the costs of a second opinion physician. A Medicare patient can obtain a list of second-opinion physicians by contacting the nearest social security office.

B. HOSPITALS

When a person chooses his physician, he also chooses his hospital. Most doctors are affiliated with only one hospital in a community and, therefore, can admit their patients to that hospital only. Occasionally, a doctor may have an agreement with more than one hospital to admit patients. When choosing a physician, it would be advisable to check to see with what hospitals he is associated.

1. TYPES OF HOSPITALS

Voluntary, non-profit, community hospitals These are hospitals owned and operated by religious groups, the community or other voluntary auspices. Generally, they offer good medical facilities and competent staff. They are also smaller in size than government supported hospitals. Voluntary hospitals are often rated as the consumer's best choice.

Proprietary These hospitals are established to make a profit for their investor-owners. Although they are intended to help sick people, they often have plush surroundings and concentrate on illnesses that can be treated relatively simply such as hernia operations, routine deliveries, tonsillectomies, etc.

A proprietary hospital would not be one's choice if one were having open-heart surgery or kidney transplant surgery. If a person were to have such complicated surgery, he would want to choose a hospital where such procedures were performed frequently.

Government-supported hospitals These hospitals are supported by state or city governments and are often teaching hospitals associated with a state university. They can offer excellent services and provide the indigent with medical care.

2. ACCREDITATION

A person should check to be sure that the hospital his physician is associated with is accredited and has met the standards established by the Joint Commission on Accreditation of Hospitals. Most hospitals post a sign which states that they are accredited, or a person can inquire at the hospital information office.

3. COSTS

Hospital costs are skyrocketing and can be more than $100 a day for routine care. The cost depends upon the type of hospital, location, size, management, and services it offers. Hospital costs can be greatly reduced if a person follows a few simple guidelines:

1. Avoid being admitted to a hospital on Friday, Saturday, Sunday or a holiday. Generally, hospitals are lightly staffed on week-ends or holidays and will not be able to administer more than custodial care. A person will be paying for a hospital bed and board unnecessarily.

2. Have diagnostic tests done on an outpatient basis, if possible, unless the costs of the tests will not be covered if the patient is not hospitalized.

3. Choose a semi-private room. Insurance generally only covers semi-private rooms and the patient will be required to pay the difference for a private room which is always higher.

4. Check itemized bills carefully to be sure only those services utilized are charged.

5. Use home health care when available.

6. Check to see if a television or telephone is billed separately. A patient can avoid the unnecessary

costs of a T.V. or telephone in his room by catching up on some reading or bringing a radio.

4. PATIENT RIGHTS

Patients also have rights in any hospital in which they are treated without regard to income, race, creed or sex. A patient's "Bill of Rights" appears in the Appendix and should be discussed with your clients. Many hospitals also have a patient advocate who assists the patient in communicating complaints about services or billing problems to the staff or administration.

5. HILL-BURTON PLAN

For a discussion of the Hill-Burton Plan, a method of providing free hospital care for medically indigent patients, please turn to Section V, Part E.

TEACHING TECHNIQUE

GOAL: To provide clients with the information they will need to choose a physician and/or a hospital.
To teach clients how to talk to their physicians more effectively.

OBJECTIVES: 1. To inform clients about the kinds of physicians available to them

2. To provide clients with the kinds of questions to ask their physician in order to communicate with him/her more effectively.

3. To inform clients of the resources available to them in the community.

4. To inform clients of where to seek affordable hospital care.

STRATEGIES: Small group work

1. Group discussion. Open discussion with a shared experience: How did you choose your doctor? Each person should share one example, including the group leader. Ask each person to analyze their own method, was it good or bad? Don't judge others. Interject some other methods which have been recommended.
Next, ask clients if they ever have any difficulty asking the doctor questions or getting information from him. Suggest questions to ask. Use handout, "Questions to ask the doctor" which has been provided in the appendix of this book and may be duplicated.

2. Audio-Visual. Show the group the filmstrip, "Buying Health Care" which can be borrowed through our office. This filmstrip discusses the ways to choose a physician or hospital. Review points made in the filmstrip with the group.

3. If applicable, discuss methods of cutting hospital costs and the patient's "Bill of Rights".

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IV. METHODS OF PAYMENT

A. HEALTH INSURANCE

Many low-income people qualify for Medicaid and, therefore, have no need to have health insurance. However, there are still poor people, who earn a modest wage, who do not qualify for any assistance. It is these people who need to purchase some type of medical insurance that will cover at least part of their medical expenses. Hospital and medical costs are increasing so rapidly that an illness which requires only a short-term hospital stay or an unforeseen birth complication can leave a poor person with large debts.

Before purchasing insurance, a poor person should be counseled to investigate the benefits available through his employer's group insurance plan. If an employer offers adequate coverage, then the person might only want to purchase a supplemental policy which will take care of family expenses or health needs during times of unemployment. If the employer does not offer good coverage or any coverage, then the person will want to purchase a good basic plan. There are five types of health insurance: Hospital expense, surgical expense, physician expense, major medical and disability.

1. TYPES OF HEALTH INSURANCE

Hospital Expense Insurance This kind of policy is often combined with surgical expense and physician expense insurance for basic health expense coverage. Hospital expense insurance usually covers full or partial payment for hospital room and board, routine nursing care, lab tests and X-Rays, drugs and medicines prescribed while a person is in the hospital, and operating room fees. Benefit

periods (the length of time one is covered by the health insurance plan) vary anywhere from 21 to 365 days. However, because the average hospital stay is only eight days, a person might want to choose a policy with a shorter benefit period, but more coverage in other areas.

Surgical Expense Benefits for the expense of a surgeon are provided for. Generally, there is a maximum amount of coverage and anything over that limit will need to be paid by another policy or out of the patient's own pocket. The lower the limitation, the higher the premium payments will be, so one would need to decide how much risk one could afford to take.

Physician Expense Insurance This insurance would cover a specific number of visits made by the doctor while one is in the hospital. Some policies also cover benefits for home and office visits.

Many standard policies exclude certain preexisting conditions, that is a disease a person has at the time he purchases the policy. Maternity benefits may also be excluded. There may be a waiting period before a person can actually be covered by benefits. A person should read the policy carefully so that he knows exactly what is covered.

Major Medical Insurance A serious accident or severe, long-term illness can deplete a family's finances, leaving them with a life-long debt. Major medical insurance coverage protects against such occurrences. Major medical insurance starts protection where basic coverage ends. Almost any kind of care and treatment prescribed by a doctor is covered. Coverage is limited to a maximum amount which can range from $5,000 to $50,000 or greater (coverage between $20,000 and $50,000 is realistic). Generally, there is an initial deductible - from $100 to $1,000 - and after that the policy owner pays a small percentage of the bill and the company covers the remainder. It is better to own a policy which covers a percentage of the bill (e.g. 80%) than one which pays a fixed amount. A fixed amount will cover a smaller percentage of the bill as hospital and medical costs increase. Most major medical coverage is sold under group plans as part of a comprehensive medical insurance plan. It can also be purchased in conjunction with a basic plan.

Disability The purpose of disability insurance is to protect a person against lost wages in the event that he cannot work because of a serious illness or injury. Disability insurance will usually cover about 60% of a person's gross earnings, if he is an average wage earner. The younger a person is when he buys the policy, the cheaper it will

be because one's risk increases with age. Once a person has disability coverage, he should hold on to it. It is less expensive to expand the benefits of an old policy than to try to get a new policy. Also, it is a good idea for a person to try to get a non-cancellable policy that offers protection through a person's entire working life. Some policies may have a waiting period before benefits are paid. Check to see which one is most practical. A policy with a one year waiting period may be virtually useless except in the case of a permanent disability; a better policy might be one which becomes effective 30 days after the onset of an illness or injury. Many employers provide for disability benefits in the event that an employee is injured. A person should inquire about what that coverage is before purchasing additional insurance.

2. SHOPPING FOR HEALTH INSURANCE

Health insurance can be purchased through commercial insurance companies or non-profit organizations such as Blue Cross and Blue Shield.

Group insurance is usually 15% - 40% cheaper than individual or family policies and can be purchased through a person's place of employment. It is usually less expensive because an employer pays part or all of the premium. If a person desires additional coverage, he can purchase a supplemental policy that covers the areas the group insurance doesn't. A supplemental policy would also assure coverage during periods of unemployment.

If a person's place of employment doesn't offer group health insurance or if a person chooses not to participate in an employer's plan, he will need to purchase an individual policy. The best rule of thumb is to "seek broad protection first". One should insure oneself and one's family against the most serious and disastrous losses that can result from an accident or illness. Coverage should be able to pay at least 75% of the anticipated expenses which may result from that accident or illness.

Check the policy carefully for exclusions and waiting periods. Compare several policies from different companies to see who offers the best benefits for the money.

If at all possible, pay premiums on a semi-yearly or yearly basis because they are less when paid less frequently. Premium payments can be apportioned monthly in one's budget so that the money is available when it is time to make the payment.

If a person has a family, he should check to be sure that children are included in the policy from birth, and not, as in some cases, from age two.

Does the policy cover mental illness or dental work?

Avoid duplicating policies. Most insurers cooperate on payments, therefore, a secondary policy will only pick up those costs that the first doesn't cover. If a person chooses to purchase a supplementary policy he should read it carefully to be sure it is compatible with the primary policy.

3. MAIL ORDER HEALTH INSURANCE

Magazines, newspaper supplements and television often have advertisements for insurance that pays up to a certain fixed dollar amount a week in benefits. The amount is fixed and often covers very little when computed on a daily basis. Mail order insurance is not a very good buy. At best, it should only be used as a supplement for a good, basic insurance policy. Premiums for mail order insurance are not tax deductible. It is cheaper, but then one pays for what one gets. Blue Cross and Blue Shield will cover up to 90% of a hospital bill, while mail order insurance may only cover 25% - 60% (at best) of the bill.

4. INSURANCE COMPLAINTS

To find out what companies are licensed to sell insurance in Virginia, or to register a complaint against a company call the State Corporation Commission. They have a toll-free number which is available to all people calling from within the boundaries of Virginia. The number is 800-552-7945.

B. MEDICAID

Medicaid is a comprehensive, health assistance program jointly funded through federal, state and local tax dollars. The purpose of Medicaid is to improve the health of people who might otherwise go without medical care for themselves and their children. Medicaid benefits everyone by reducing disease and disability throughout the country.

Each state has its own separate program so that services covered by Medicaid and eligibility requirements

will vary from state to state. In Virginia, Medicaid will pay for such services as inpatient hospital services, outpatient hospital services, outpatient laboratory and X-ray services, skilled nursing services and home health services, and physician services such as office visits, hospital care, hospital outpatient care and family planning services.

Under a special children's program called Early Periodic Screening, Diagnosis, and Treatment (EPSDT), children receive routine check-ups to monitor growth and development, vision, hearing and dental needs, as well as to detect diseases such as heart or kidney disease, tuberculosis, venereal disease, ear, eye, nose, and throat disorders, anemia, parasites, lead poisoning and drug abuse. Children will also receive all routine immunizations. Recipients of Medicaid can also have prescriptions filled for 50¢ each or eyeglasses made for $2.00 a pair.

People who qualify for Medicaid are families who have dependent children and who have a low-income, people who are aged, blind or disabled and have little or no income, people whose medical costs are so high that they cannot meet their daily needs (medically indigent) and people who receive assistance through supplementary social security income (SSI). In order to qualify for Medicaid, a person does not need to sell his home as long as it is his dwelling place (i.e. not a second home) and he may have assets which are sufficient to cover his burial needs. Eligibility requirements do change and often depend upon one's present circumstances so it is best to investigate before deciding one is not eligible. A person can apply for Medicaid benefits through the State Department of Welfare.

Medicaid is such a comprehensive health assistance program that people who qualify do not need any additional health insurance coverage. However, one should be sure that the physician one chooses accepts Medicaid payments - not all physicians do.

C. MEDICARE AND SUPPLEMENTAL INSURANCE

Unlike Medicaid, Medicare is an <u>insurance</u> program. Medicare is available to all people over 65 and, in some cases, to people under 65 with particular disabilities. It is federally funded and administered through the social security program.

Under Medicare there are two programs, Part A and

Part B. Part A provides for hospital benefits and is available free to those who qualify. Part A pays for medically necessary in-hospital care and medically necessary skilled care in a nursing home facility or 100 visiting nurse visits for home health care after a hospital stay. The patient pays $207 of his hospital expenses, then Medicare will pay for all covered services for the first 60 days of inpatient care during a benefit period. If a patient is in the hospital for longer than 60 days, he will need to pay $45 a day for all covered services and Medicare will pay the remaining portion. A benefit period begins the first day a person begins receiving Medicare and ends when the person has been out of a nursing home or hospital for 60 days in a row. If a person enters the hospital again after those 60 days, a new benefit period begins. There is no limit to the number of benefit periods a person can have.

A person also has a 60-day lifetime reserve if more than 90 days are needed for in-patient hospital care during a benefit period. When those 60 days, which are not renewable, are used up medicare will pay all but $90 a day for covered services. However, it is extremely unlikely that a person will ever use up his lifetime reserve or be hospitalized for more than 30 days, for the average hospital stay is about eight days.

Part A will also pay for all skilled nursing care in an approved nursing home for the first twenty days after release from a hospital. For the next 80 days, Medicare will pay all but $22.50 a day for covered services. Medicare will not pay for nursing services which are primarily custodial even though they are performed in an approved skilled nursing care facility.

Part A will pay the entire cost of up to 100 medically necessary home health visits after a hospital stay. These visits must occur within one year from the patient's most recent hospital discharge. Medicare will cover the part-time services of a visiting nurse or physical or speech therapist from a certified home health agency. Part A will not cover full-time nursing care, drugs, meals delivered or homemaker services that are primarily to assist a person in meeting personal care or housekeeping needs.

If a person is eligible for Part A of Medicare, s/he will also be eligible to subscribe to Part B. Part B is an optional medical insurance which covers doctor's bills and other medical services. Although subscribers must pay

$9.60* a month for coverage. Part B is one of the best health insurance buys to be found, because the government is required to pay half the cost of the program. A person will always get twice as much protection as he pays for.

However, if a person has been enrolled with a company or union health plan that will continue after he retires, he may not need Medicare Part B. It is important to investigate that option before deciding to enroll in Part B. A person can decline Part B and then decide to enroll at a later time. One should be aware that like any insurance policy, as one gets older, the cost of Medicare increases 10% per year for each year a person elects not to subscibe. So, if a person decided not to subscribe until age 75, the cost per month would be double the cost at age 65, or $19.20 per month. The 10% increase is based on the monthly premium for that fiscal year. Medicare could become quite expensive for a person who declined it initially.

Part B pays for 80% of all reasonable charges for covered services after the patient pays the $60 deductible. Those services covered by Part B are doctor's services, outpatient services, laboratory services, X-Ray and radiation therapy services, 100 home health visits a year (without first being in the hospital), physical therapy and speech therapy, durable medical equipment, limited ambulance services and prosthetic devices and other medical supplies and equipment.

A patient should check with his physician to determine if he will accept assignment; that is, charge the amount that Medicare deems reasonable for that particular fiscal year. If he does accept assignment then the patient will pay 20% of the bill and Medicare will pay the remaining 80%. If the doctor does not accept assignment, then he can charge what he chooses. Medicare will still pay 80% of the reasonable charge. But the patient will pay 20% plus the difference between what the doctor charges and what Medicare says is reasonable.

For instance, a patient's doctor who does not accept assignment charges $50 for an office visit with X-Rays and EKG. Medicare says that $40 is a reasonable charge. Hence, Medicare will pay 80% of the $40 or $32; the patient will pay 20% or $8.00 plus the $10.00 difference or $18.00.

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*scheduled to increase to $11.00 per month on July 1, 1981.

There are other gaps in Medicare, or areas where Medicare does not cover fees. They are:

a. private duty nursing
b. skilled nursing home care costs (beyond the benefits)
c. custodial nursing home care
d. intermediate nursing home care
e. home health care over 100 visits
f. drugs, other than those received during a hospital confinement or under skilled nursing home care.
g. care received outside the USA
h. dental care, routine foot care, eyeglasses, hearing aids, immunizations, and cosmetic surgery

Medicare becomes effective on the first day of the third month after one enrolls. So people should enroll three months before their 65th birthday to avoid not being covered for three months after they turn 65.

SUPPLEMENTAL HEALTH INSURANCE

Medicaid will cover all those expenses not covered by Medicare. However, not everyone is eligible for Medicaid. Unless one is eligible, he will need to buy additional supplemental health insurance. A person who is interested in additional health coverage should be cautioned against buying more than s/he needs. Many times older people will purchase several policies in an attempt to get full coverage for all health care costs. It is literally impossible to get full coverage and a person may find that they are paying more for coverage than it is actually worth. One policy that is designed to cover most of the gaps in Medicare is recommended. There are several kinds of supplemental insurance programs which have either individual, group, or limited coverage.

a. Individual or Group Supplemental Insurance

Often called Medicare Supplemental, this coverage will pay some or all of Medicare's deductible and co-payments. It may also provide for some health services not covered by Medicare. However, like Medicare, it often will not pay for unnecessary costs such as a T.V. or telephone in one's hospital room.

b. Catastrophic or Major Medical Expense

This type of coverage helps to cover the high cost of serious illness or injury including some health services not covered by Medicare. The deductible will be larger

than the Medicare deductible and this particular kind of policy may not cover the deductibles and co-payments of Medicare.

c. Health Maintenance Organizations H.M.O.s offer comprehensive health care and will be discussed at a later point in this booklet.

d. Group Supplemental Health Insurance

1) Employer Group Insurance- Coverage is continued after retirement or can be converted to a suitable Medicare supplemental policy after age 65. The advantage of this kind of policy is that there are no waiting periods or pre-existing condition exclusions.

2) Association Group - If a person belongs to the American Association of Retired Persons, Lions, Elks or other fraternal organization, he may wish to purchase the supplemental health insurance offered through that association.

e. Limited Coverage

1) Nursing Home Care This type of policy pays for skilled nursing home care, not intermediate, rest or custodial care. A person who is thinking of purchasing this kind of policy should read the policy carefully to be sure they know exactly what kind of nursing care is covered and whether or not it has to be provided in a Medicare-approved nursing home. If it provides for the same coverage as Medicare, then it's not worth buying, for it will only pick up those costs that remain *after* Medicare pays.

2) Hospital Confinement Indemnity This type of insurance is often sold through the mail and will offer to pay a fixed amount per week in cash for "all" expenses. For instance, a policy may pay up to $100 a week in cash. If a person divides $100 by 7, he finds that the policy pays $14.28 per day - hardly enough to cover one's medications, let alone room, bed, nursing services, etc. Because this type of policy is an indemnity (a fixed amount) payment, it is not inflation proof. It is best to purchase a policy that pays a percentage of the costs and those costs should ideally be reevaluated at least once a year.

3) Specific Disease Coverage The benefits received from this kind of policy are not meant to cover Medicare gaps. Rather it is meant to cover the high cost of a particular disease such as kidney disease or cancer. If a person's parents, siblings, and other close relatives

have all succumbed to a particular disease such as cancer, then his chances of getting that disease are far greater than the average; therefore, the person might wish to consider special disease coverage. However, he should read the policy very carefully to be sure that he knows exactly what will be covered.

GUIDELINES FOR PURCHASING MEDICARE SUPPLEMENTAL INSURANCE

When purchasing Medicare Supplemental Insurance, a person should compare and evaluate several different kinds of policies, then buy the *one* that compliments his Medicare benefits best. He should:

a. Check for preexisting condition exclusions and waiting periods. Even though a new policy offers better coverage at a better rate, a person should hold onto the old policy until all required waiting periods are past.

b. Be aware of maximum benefits and what they mean. If a policy states that the company will pay up to $100 a week, it means that they will pay no more than that. Will $100 a week be enough additional coverage?

c. Check the right to renew - be sure it's the consumer's right, not the company's, so that he doesn't find his coverage being arbitrarily dropped by the company.

d. Don't withhold medical information. If information is withheld, a company can cancel the policy or increase the amount of the premiums.

e. Get an outline of exactly what the policy covers in simple English.

f. Take time before signing any policy. Don't be taken in by scare tactics. Check to see if the policy contains a ten-day "free-look" provision. A person won't be under any obligation if he decides, within that time frame, that the policy is not suitable.

g. Pay for the policy by check written to the *insurance company*, not the agent. Never pay cash!

TEACHING TECHNIQUES

GOAL: 1. People will know how to evaluate health insurance policies and choose one which is most suitable for their needs.

2. People will be more aware of their benefits under Medicare and Medicaid.

OBJECTIVES: 1. To acquaint people with the language used in insurance policies.

2. To teach people how to get basic information from a policy.

3. To compare and discuss several policies.

STRATEGIES: 1. Compile a list of words used most commonly in insurance policies. Give simple meanings for each. Discuss each word with the group and explain how they are used in policies.

2. Take several policies, break down into key phrases. Discuss what these phrases mean. Interpret a policy in simple English. Keep discussion light, don't place pressure on the group to perform.

3. Ask people to bring their insurance policies with them to the meeting. Discuss benefits and coverage. If a person's coverage seems to be inadequate, have the group members suggest alternatives.[1]

4. Invite a volunteer* from the community who is knowledgeable about insurance to speak to the group. (Be sure that he won't try to sell insurance to the group). Have the group prepare questions in advance about their own policies so that the talk can be more personalized.

5. Use an audio-visual aid to acquaint participants with the benefits of Medicare and Medicaid. Our office has a videocassette entitled, "Medicare/Medicaid" which can be borrowed on a free-loan basis.

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*Source: R.S.V.P. in Charlottesville, Virginia has a volunteer organization called SHIBA (Senior Health Insurance Benefit Advisors). These volunteers are trained to evaluate Medicare Supplemental Insurance policies. They have been successful in eliminating useless, costly policies for many senior citizens. For more information, you may telephone 804-296-8211.

[1] Charts for comparing benefits and costs for insurance policies, as well as Medicare benefits with benefits from supplemental insurance are located in the Appendix and may be used with clients.

V. HEALTH CARE ALTERNATIVES

The traditional health insurance/fee-for-service physician pattern is one of the more costly ways to finance health care. There are alternatives to that situation. Health Maintenance Organizations, hospital clinics, health department clinics, and others all provide good medical care. In the following section we will explore these alternatives. What the individual chooses depends upon how much s/he can afford to spend, what s/he feels comfortable with and, in some cases, whether or not s/he qualifies for assistance.

A. HEALTH MAINTENANCE ORGANIZATIONS

The first Health Maintenance Organization (H.M.O.) was established in California during the 1930's. Members of an H.M.O. share the costs of maintaining their health as well as the expense of treating illnesses. The concept of an H.M.O. is to reduce the costs of health care by providing medical services for an annual fee which can be on a sliding scale dependent upon income. The annual fee will cover all services such as office visits, lab tests, immunizations, and hospital confinement costs. The hospitals utilized are members of the organization.

There are two kinds of H.M.O.s, Prepaid Group Practice and Individual Practice Associations. Under a Prepaid Group Practice Plan a member receives care from physicians employed by the plan at the plan's facilities. These physicians are salaried and are not paid on a fee-for-service basis. An Individual Practice Association is more like the traditional fee-for-service plan. Physicians continue to work out of their own office, but follow a schedule of "usual and customary fees". If a physician charges more than the fee schedule, then he must make up the difference.

The annual fee to join a Health Maintenance Organization is generally much lower than traditional insurance coverage. In studies done on Kaiser Health Maintenance Organizations (California), it was found that medical care expenditures averaged about 30% less than expenditures by Blue Cross/Blue Shield enrollees. In an H.M.O. plan one pays the annual fee; however, after that there is no deductible, or co-payment allowance. The fee covers everything with the possible exception of prescriptions, X-Rays, lab charges, or office visits, and these will only be charged nominally. Other services included in the fee are preventive health care counseling classes such as weight reduction and "Quit Smoking" clinics. Some H.M.O.s even provide dental care or mental health care.

The reasons for the reduced costs seem to be that: 1) Hospital in-patient services are used less frequently both because the H.M.O. clinics are equipped enough to provide their own diagnostic testing without hospitalization and because the patient does not have to be hospitalized to cover the costs of these tests. 2) Preventive health care is a routine aspect of H.M.O.s. Also people are inclined to follow through with annual physicals so that early disease detection can occur. 3) H.M.O.s make greater use of mid-level professionals such as nurse practitioners, physician assistants, and para-medics. These mid-level practitioners can take medical histories, give immunizations and do routine exams, thereby cutting down on the use of primary care physicians whose services cost more.

The quality of H.M.O.s is generally superior to traditional fee-for-service practices. The majority of physicians practicing at an H.M.O. are board certified and have graduated from an American medical school. Also physician practices are constantly reviewed by their peers. Unmarked medical records are given to other doctors for review. Then critiques and responses are given before a formal board. Informally, primary and secondary physicians are working in the same facility and can exchange viewpoints on patient care. H.M.O.s are also regulated more carefully by government standards than fee-for-service practices.

Costs and quality seem to be the greatest advantages for H.M.O.s. There do appear to be a few disadvantages, however. The primary disadvantage for Virginians is that there is no state contract for H.M.O.s to treat Medicaid patients. However, Medicare patients can receive treatment through an H.M.O. Also, patients whose income is too high to qualify for Medicaid, might do well with the sliding fee schedule utilized by many H.M.O.s.

It is more difficult to establish a good patient-doctor relationship in an H.M.O. because one has no choice about one's physician. A family or an individual is assigned a physician when they join the plan. Many low-income people don't like H.M.O.s because of the sense of bureaucracy that they encounter. There also seems to be a longer waiting period before getting an appointment to see a doctor. H.M.O.s seem to work best in urban areas where there are more medical specialists who have access to a number of hospitals and laboratories in the area. Therefore, H.M.O.s might not be convenient for people living in outlying or rural areas.

If a person is interested in joining an H.M.O. he should:

1. Find out if any H.M.O.s exist in his area.

2. Check with his employer's personnel office to see if an H.M.O. plan is offered as an alternative to group health insurance. A recent law requires employers of 25 or more people to offer their employees the choice of group health insurance or a Health Maintenance Organization if one exists in the area.

3. Find out when new memberships are taken.

4. Inspect the H.M.O. facilities and ask:
   a. What hospitals are members of the H.M.O. plan?
   b. Is it federally funded?
   c. Are they taking new members?
   d. What is the waiting period for services?

Remember, Health Maintenance Organizations will honor Medicare recipients and will pick up those deductibles, co-payments, and gaps not covered by Medicare.

If a person has the choice, s/he should consider an H.M.O. as as excellent, cost-effective method of health care.

B. OUTPATIENT CLINICS

1. HOSPITAL OUTPATIENT CLINICS Hospitals often maintain outpatient clinics whose services are free or on a sliding fee schedule. The best clinics are those associated with a teaching hospital like the university schools of medicine. In order to find out if there is such a clinic in one's area, telephone the nearest accredited hospital or medical school. Also call in advance for an appointment, directions to the clinic, and information about any preliminary examinations.

Some hospitals are teaching centers for Family Practice Physicians. These hospitals also maintain clinics which are available for public use. One can check to see if such a clinic is available in one's area by telephoning the local hospital information service.

2. COMMUNITY HEALTH CENTERS These centers are located in medically underserved urban or rural areas. They offer comprehensive health services on a sliding fee schedule. There may be some residential restrictions. The

local county health department or social service agency would know if these clinics are available in the area.

3. COUNTY HEALTH DEPARTMENT A gamut of clinical services which are either free or on a sliding scale are maintained by the health department. These services include Ambulatory Care Service which is a health screening device and is free, a pediatric clinic which offers well-child check-ups on a sliding fee basis, immunizations and VD clinics which are free, a family planning clinic, speech and hearing clinic, chest clinic for TB patients, a Developmental Center for learning disabilities, a shot clinic for overseas immunizations, and an X-Ray department which will administer tests at the request of a physician. These X-Rays and immunizations are given at considerably less expense than those provided by a doctor's office, although they are not free.

4. HEALTH SCREENING PROGRAMS Privately funded social service agencies such as the American Cancer Society, the American Lung Association, and the American Heart Association will offer free screening clinics in order to detect early colo-rectal cancer, TB or other lung diseases, and high blood pressure. Advertisements for these clinics are usually broadcast over local radio stations or reported in newspapers. In addition to screening clinics, these private foundations offer a variety of other services for medically indigent patients such as transportation to and from doctor or treatment clinics, some financial aid for medications, loan closets for medical equipment, etc. A list of these foundations and their services appears in the Appendix.

Schools also offer screening clinics for ambliopia, and other vision problems, hearing defects, spinal curvature, parasites, dental decay and other problems. In addition, annual physicals are administered by the school physician at no cost and only need a parent's approval.

5. MENTAL HEALTH CENTERS Under the direction of the Community Services Board, outpatient mental health clinics have been established throughout the state. There are currently thirty-seven in operation. The services offered vary according to the needs of the jurisdiction; however, those services generally offered include alcohol and drug abuse counseling and rehabilitation, group homes and respite care for the mentally retarded, community education, emergency treatment, twenty-four hour "hot lines", individual and group therapy, screening and referral. These services are available to all income levels on a sliding fee schedule. For more information, contact the Department of Mental Health, Retardation and Substance Abuse' information office in Richmond. The number is 804-786-3909.

C. EMERGENCY ROOM TREATMENT

Emergency rooms are just that - a place to treat a life-threatening illness or acute condition. Emergency rooms should not be utilized for non-urgent cases primarily because the cost of using an ER for such a situation can be two to three times the cost of calling one's physician or being seen at an ambulatory care clinic.

A condition which has existed for several days and has remained unchanged during that time, is not likely to impair life or function if it continues until one can see his doctor. Often people rush to emergency rooms when they are suffering from a cold, sore back, minor sunburn, etc. The result for them is long waiting times, because acute emergencies are always seen first, and big bills. Frequently, the treatment is superficial and the patient is urged to call his physician in the morning. A non-emergency situation can easily wait until one has a chance to telephone one's physician or health clinic and check with them about proper treatment.

Emergency rooms should be used for urgent conditions only: severe pain, swelling, difficulty in moving a limb, severe burns, high fevers (102^{o} or greater), heavy, uncontrolled bleeding, or any new and acute condition such as severe vomiting or lack of consciousness.

Before hurrying off to an emergency room, a person should call his physician and describe the condition. If the situation is an emergency, he can tell the patient what emergency room to go to, call ahead and give the required tests and treatments, arrange to meet the patient there, and recommend an ambulance. If the situation is non-threatening, the doctor will recommend treatment or schedule an appointment.

It might be beneficial for clients if you compare the costs of emergency rooms for non-emergency use with physician fees. Emergency room treatment for a life-threatening illness such as a heart attack is often covered by health insurance benefits. However, health insurance would not pick up the costs of routine treatment. It would also be helpful to clients if they were taught the difference between urgent medical problems and non-urgent problems.

If a person contemplates using an emergency room, he should shop around, when the situation is not a life-threatening one, for the ER that has the shortest waiting time and lowest fee schedule. He should also be certain that the particular emergency room that he chooses is associated with a certified hospital and has a good reputation.

D. LONG-TERM CARE

1. NURSING HOME CARE

Occasionally, after a hospital stay, it is necessary for a patient to have continued long-term nursing or convalescent care. One will probably first think of a nursing home; but, before making a definite decision, one should first investigate the alternatives to nursing homes such as adult day care, senior citizen housing and home health services. Nursing homes provide three different kinds of care: Skilled, intermediate, and custodial.

a. SKILLED NURSING HOME CARE provides continuous medical supervision by a professional registered nurse and physician. Services provided would include such things as oxygen therapy, administration of intravenous fluids, skilled rehabilitation, etc. Medicare and Medicaid will pay for skilled nursing care under certain circumstances. A nursing home has to be certified by Medicare or Medicaid in order to receive payment from the government.

b. INTERMEDIATE CARE A person needing intermediate care would not need as extensive care as a skilled nursing patient. Intermediate care would provide basic medical and personal care such as the changing of surgical dressings, administration of medications, exercises and assistance with routine habits such as bathing, dressing, and eating. Medicaid will pay for intermediate care in some cases; however, Medicare will not. A further caution should also be noted here: If a person will be eligible for Medicaid coverage when Medicare benefits stop, it will be important to determine at the outset if the nursing home will accept Medicaid payments. If not, it may be necessary to move the patient to another home when Medicare benefits stop.

c. CUSTODIAL CARE or RESIDENTIAL CARE is not covered by either Medicare or Medicaid. Custodial care is designed to provide for the physical, social, recreational, and spiritual needs of the residents rather than medical needs. Residential care facilities are especially good for elderly people who, while not ill, are frail or forgetful and need supervision in providing for their dietary and housekeeping concerns. They also provide companionship for a person who would otherwise be isolated. Alternatives to custodial nursing care are adult day care, senior housing and community support systems.

d. CHOOSING A NURSING HOME

When choosing a nursing home for a patient one should first consult with the patient's physician to determine the level of care needed and if an alternative to a nursing home, such as home health care, would be adequate. If a nursing home is what the physician recommends, the next step is to determine how the care will be financed. If the patient is eligible for Medicare, then one would want to find a home that is Medicare certified. If the person will be paying for nursing care with benefits from group health or private health insurance, consult with the employer or insurance company to determine exactly what is covered.

In order to find out about nursing homes in one's area, one should check with the local Area Agency on Aging, the hospital social worker or the Virginia Health Care Association. Both the Capitol and Fairfax Area Agencies on Aging publish an excellent booklet which lists nursing homes in those areas along with the services provided and costs for care.

The patient should be as involved as possible in the selection process of the nursing home, so that the decision is as much his/hers as the caretaker's. From the list or nursing homes, one should select at least three which look to be the most suitable. An appointment should be made to visit each of them at a time when a person will have a chance to visit with the residents. A checklist of criteria for selecting a nursing home is included in the Appendix. Use the checklist as a guide and if there are any questions, make a second, unannounced visit to the nursing home.

e. SIGNING A CONTRACT

At the time a person is admitted to a nursing home, a contract will be signed which clearly states what services the patient will receive and how these services will be paid. It is important, therefore, to investigate thoroughly beforehand, exactly what private health insurance will cover, whether or not the nursing home is certified by Medicare or Medicaid, or if the home accepts payment from either. A family member may also sign a contract as Guarantor; that is, he guarantees to pay the nursing home for any and all care the patient receives that she cannot cover from her own resources.

Another method of financing long-term nursing care is a Life-Care Contract, whereby, a patient assigns his property and money to the nursing home in exchange for

room, board, and other care provided by the nursing home. A person should be very cautious about signing a contract such as this to be certain that in case he improves and no longer needs the services of the home, he can break the contract and not become a virtual prisoner in the home. In addition, the services which are promised by the home should be clearly defined. It is often hard to prove the "quality of care" which was promised was or is not adequate.

f. PATIENT REDRESS

In 1976, the Virginia General Assembly adopted a comprehensive patient's bill of rights for nursing home residents in which it was mandated that a person had a right to complain to outside sources without fear of reprisal. A patient should first discuss the problem with an appropriate member of the staff. If the problem remains unresolved after a reasonable period of time, the patient or family member should call:

Citizens Assistance Unit
Virginia Office on Aging
830 E. Main Street, Suite 950
Richmond, VA 23219
(804) 786-7894

2. HOME HEALTH CARE

One alternative to long-term hospitalization and nursing home care is home health care, if a patient only requires part-time medical supervision. In home health care a person - young or old - can recuperate from a long illness or have palliative care for a fatal illness in the comfort of his home. Home health care costs are generally much less than hospital or skilled nursing care and can be covered by most health insurance programs or Medicare and Medicaid.

Generally, it is necessary to have a least one family member in constant attendance. Nursing care is provided by the county health department visiting nurse service or a proprietary home health agency. The nurse assigned to the case will come several times a week to check on the patient. Home Health Aids can also be contracted to provide for the routine daily needs of the patient. Hospital equipment such as beds, toilets, wheel chairs, rails, etc., can be rented from local hospital supply businesses or pharmacies, or borrowed from loan closets provided by social service agencies (see Appendix).

3. HOSPICE

Home health care is gaining increasing support under the Hospice movement, for patients dying of cancer. The original word, Hospice, meant a resting place for weary travelers. In modern times, it means a special kind of care for patients who are in the terminal stages of cancer.

In order to receive Hospice care, a person must be diagnosed as being within a few months of death. Under Hospice, a patient is removed from all external support systems given in hospital and goes home. He is given only palliative care, i.e. chemotherapy or medication to reduce the pain and discomfort of the disease. A team of professional and highly trained volunteers offer supportive care. A nurse visits the patient several times a week, a doctor is "on call", and home health aids or volunteers administer to the daily needs of the patient. A social worker and pastoral counselors are also available to counsel the patient and his/her family in order to prepare them for the patient's imminent death. Follow up care after the patient's death is also provided for families. Hospice care is generally less expensive than total hospitalization because it requires fewer professional services. However, the patient can still be treated in hospital if his illness becomes too severe for the family or hospice team to manage. The Hospice concept allows the patient to die in the familiarity and comfort of his own home as opposed to dying in the sterility of a hospital or relying on life support systems until the bitter end.

A patient can check with his physician, hospital social service department or county health department to find out how to apply for Hospice or Home Health Care in his community.

E. HILL-BURTON PLAN

The Hill-Burton Plan is also known as Title VI or XVI or the Public Health Service Act. Under this plan, Congress will disburse money in the form of grants, loans, and guaranteed loans to hospitals and public health facilities for modernization, improvement and expansion of their existing facilities or construction of new facilities. Those facilities receiving the funds have to comply with the two mandates of the plan: To provide service without discrimination to all residents or people employed in the jurisdiction of the facility and to provide a reasonable volume of services to those persons unable to pay.

Under the first mandate, a facility that has received Title VI or XVI money must provide services to all residents or persons employed in the community without regard to race, color, national origin, creed or any other reason which is unrelated to an individual's need for the service or the availability of the needed service in the facility.

A hospital can deny general services to a person if s/he is unable to pay unless s/he qualifies for uncompensated care. However, a hospital may not deny emergency treatment to any person who resides in the facility's service area because s/he is unable to pay. Under such circumstances, the facility can administer the emergency treatment and then have the person transferred to another treatment center when it is medically advisable. In addition, facilities who receive Title VI or XVI money must accept third party payer programs such as Medicaid and Medicare and overcome exclusionary admissions policies such as pre-admission deposits and admission by staff referral only or any other policy which would bar medically indigent people from receiving adequate health treatment. For instance, a hospital may still require that only physicians who are affiliated with the hospital admit patients. However, the hospital can either request that several physicians who are staff members agree to admit patients other than their own or the hospital can establish a clinic through which patients can be admitted directly.

Under the second mandate, a facility that receives federal money must provide annual uncompensated care for 20 years based on 3% of its total operating costs or 10% of the federal assistance it received, whichever is less. For example, if a hospital receives $1,000,000 and its total yearly operating costs are $2,500,000, it must then provide uncompensated services for 20 years in the amount of 3% of $2,500,000 (this amount is less) or $75,000 per year. If a facility fails to provide the annual standard, then it must file an affirmative action plan in order to make the community aware of its uncompensated services. It also must plan to take a longer period of time to make up its deficit. If after following through with an approved affirmative action plan, community response is still low, then it will be assumed that community need has been met.

A facility can provide uncompensated services to persons who fall into two catagories. It must provide services without charge to persons under Catagory A. These are persons whose individual or family income, as applicable, for the 12 months preceding the determination of eligibility is not more than the current poverty

income guideline of the Community Services Administration that applies to the individual or family. Catagory B persons are those whose individual or family income for the 12 months preceding the determination of eligibility is greater than the current poverty income guideline of CSA that applies to the individual or family but not more than twice that guideline. These persons are eligible for uncompensated services without charge or on a sliding scale basis. Income can be determined by what a person earned during the 12 months prior to eligibility or his income for the past three months multiplied by four.

Once a facility meets its mandate for a fiscal year it no longer has to offer uncompensated care until the following year; but it must notify the community when the new year begins. Notification must be posted in clear, easy-to-read signs in English, Spanish, or any other language spoken by more than 10% of the people of the community. When a person inquires about eligibility, he must be told about the uncompensated plan in writing and verbally. A person can inquire at a hospital's social service department to determine if there is a Hill-Burton Plan and if he is eligible for it.

TEACHING TECHNIQUE

Not all of the information in the preceding unit will be relevant to all of your clients. A person is most receptive to information that applies directly to his own situation. Various teaching methods are suggested in order to make the information relevant to your group.

GOAL: 1. People will be aware of the health care alternatives and resources available to them in the community.

2. People will know how to use the resources properly.

OBJECTIVES:

1. To provide clients with information about alternatives to the doctor-hospital method of health care and how to utilize the alternatives properly.
2. To provide clients with information about long-term care alternatives.
3. To provide clients with information about additional resources in the community who provide assistance with health care.

STRATEGIES:

1. Provide a workshop for middle-aged children of aging parents. Discuss the various long-term health care alternatives available in the community, e.g. nursing homes and home health care. Compare and evaluate these various methods. Provide clients with a list of nursing homes and home health care agencies in the community. Discuss the methods of evaluating a good nursing home. Use the handout, "Twenty Questions for Evaluating a Nursing Home" which is in the Appendix.

2. Provide handouts or flyers in an accessible place about screening programs, community clinics and other health care services available in the community. Contact the privately funded social service agencies and request that they notify you about any of their programs. Include the information in a newsletter for clients or post it on a bulletin board in the waiting room of your agency.

3. Invite a physician to speak to your clients about the symptoms of common ailments, what symptoms need a doctor's attention and when to seek emergency treatment. This type of discussion is always helpful for new mothers who are inexperienced about infant and childhood ailments. Have your clients plan questions for the doctor in advance of the presentation.

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VI. PURCHASING MEDICATIONS

One cost of health care that very often is not covered by insurance is the cost of medications. Only Medicaid, and occasionally, an H.M.O. will cover most of the cost of medications. Therefore, a person needs to know how to shop wisely for his medications.

A. GENERIC DRUGS

One way to lower the expense of medications is to substitute a generic drug equivalent for the brand name drug. All drugs have a generic name which identifies the types of chemical compounds included in the drug. However, these names are generally long and unreadable, so a pharmaceutical company will call the drug by an easier to remember "brand" name. The generic name is not protected by a trademark, but the "brand" name is

and identifies the drug with the company. For instance, a brand name for a drug may be Lomotil, but the generic name is dephenoxylate hydrochloride with atropine sulfate. A drug company has exclusive patent rights over a newly developed drug for 17 years. After that time is up other companies can manufacture the drug under a different brand name or the generic name.

The Food and Drug Administration controls testing of all drugs. If a drug is to be sold as the generic equivalent of a brand name drug, it must be bioassayed to determine if, in fact, it is as strong and has the same chemical effect as that of a brand name drug. Not all generic drugs are "bioequivalent". Therefore, when a doctor writes a prescription he may prefer the brand name drug to the generic drug because he knows that its particular strength and dosage is just right for the patient's ailment and metabolism. Also, the reaction of some medications can be adverse when taken with others the patient is already using.

In Virginia, a physician may consult the Virginia Voluntary Formulary to determine if a generic drug is bioequivalent. A formulary is a list of drug products. In order to be listed, a generic drug has to pass stringent quality standards which meet the requirements established by the Virginia Voluntary Formulary Council. The bodily effects the drug produces must be comparable to those of the standard or initially marketed product.

A physician in Virginia has a prescription pad which has two signature lines, one on the left and one on the right. The left signature line has "Voluntary Formulary Permitted" written beneath it. If the doctor signs this line he is telling the pharmacist that he can substitute a generic drug from the formulary which is equivalent to the name brand drug. Because of the requirements of the Voluntary Formulary Council, the patient is assured that the drug he is getting is exactly equivalent to the one his doctor prescribed.

If the physician signs the right signature line, which has "Dispense as Written" beneath it, the pharmacist cannot make any substitutions. A physician, therefore, has three options. He can write the brand name, but allow the substitution of a generic drug, he can request the brand name only, or he can request the generic drug only.

A patient should ask the doctor to prescribe the generic drug when he can because of the savings. Brand name drugs can be five to ten times or more the cost of a generic drug.

B. OTHER MONEY SAVING TIPS

Other ways to save on prescription drugs are:

1. Shop pharmacies for the best price before getting a prescription filled - especially when it's not critical to have it filled that day. Pharmacies often differ in prices charged to their customers for medications and also in the number and kinds of services offered. For example, discount drug stores sell medications at a much lower price than a standard drug store. However, a discount drug store will not deliver medications. Also, standard drug stores will accept phone-in prescriptions from a physician. So if a mother was unable to leave her sick child in order to pick up a prescription, a drug store that delivered it to her would be preferrable to trying to save money. However, a person who needed to have a prescription filled regularly would find the discount store the best alternative.

2. If an illness is chronic and the patient will be taking the drug continously over a long period of time, he should ask the doctor to prescribe it in quantity (provided there's no expiration problem). It's cheaper to buy a drug in lots of 100 than it is smaller amounts.

3. If a patient needs only a very small number of pills, he should ask the doctor if office samples are available.

4. In Virginia, over-the-counter drugs are taxed and prescription drugs are not. Very often a physician will prescribe an over-the-counter drug such as aspirin for arthritis pain. If the physician writes a prescription for it, the patient will not have to pay tax on the medication.

C. OVER THE COUNTER DRUGS

Over the counter drugs are a popular method of curing common ailments such as colds, minor fever, muscle pain, sleeplessness, sleepiness, etc. If taken properly and occasionally, they can be helpful in providing temporary relief for a minor problem. Unfortunately, they are often misused. In addition, there can be some equally effective home remedies which are much less expensive. Following is a list of common ailments, drugs and effective substitutes:

PROBLEM	DRUG	SUBSTITUTE
Pain or fever	aspirin	None - The store brand in the largest bottle available is the best buy.
Cough	Cough medicines	Home remedy of honey, lemon juice and whiskey. steam from a vaporizor (or boiling pot of water) to loosen congestion.
Muscle pain	Ben-Gay, etc.	warm, moist heat and aspirin
Common Cold	Contac, Comprex, etc.	Aspirin Rest in bed drink plenty of fluids
Sleepiness	No-Doz, Vivarin	1 cup of coffee
Sleeplessness	Sleeping Pills	*Adopt a relaxing routine before bedtime *Drink a warm glass of milk or eat a light snack before retiring *Stay comfortably warm *Sleep on a comfortable mattress and pillow *Exercise moderately during the day.

Remember to read the label before taking any medication.
If a condition persists or becomes worse, consult a doctor.

TEACHING TECHNIQUE

GOAL: People will know how to save on prescription drugs.
People will know the proper use of non-prescription drugs and how to save money on them.

OBJECTIVES:

1. To teach clients the cost difference between generic and brand name drugs.
2. To teach clients money-saving techniques when purchasing prescription drugs.
3. To teach people when to use over-the-counter medications and how to save money on them.

STRATEGIES:

1. Conduct a short workshop session. Teach clients the difference between brand name drugs and generic drugs. Discuss how they can encourage their physician to prescribe only generic drugs. Discuss other methods of saving on medications.
   Use one of the audio-visual aids available through our office which discusses the purchasing of drugs.
2. Show the audio-visual aid "Over the Counter Pills and Promises" available through our office. Discuss the film and various ways of either substituting inexpensive remedies for over-the-counter drugs or saving money on these drugs.
3. Include information on saving money on drugs in a client newsletter.

***

VII. MEDICAL QUACKERY

One of the saddest forms of fraud is medical quackery. Not only are people duped out of millions of dollars each year, they are also deprived of good medical care, their health, and occasionally, their lives.

Medical "quack" cures take all manner of guise from the very cheap to the very expensive. However, even some of the cheap cures can lead to expensive, long-term health problems. For instance, a cure for near-sightedness, farsightedness, astigmatism and middle aged eye problems cost only $9.95. Inexpensive,

yes - but, the results could lead to blindness because the course of treatment encouraged people to ignore glaucoma medications and, instead, stare at the sun. Another "treatment" which guaranteed to cure anything via the bloodstream and cost $700.00 contained products which were highly contaminated and could easily have led to severe illness or even death.

There are miracle "medical" cures for obesity, in which it is proported that a person can lose 50 pounds without ever going on a diet, or lose inches by wearing specially designed belts or sweat suits. There are miracle cures for cancer. By merely holding on to a machine and realigning one's bodily vibrations or taking unknown "miracle" drugs, one can be cured of cancer. The tragedy of this is that a person postpones medically necessary procedures until it is too late. Occasionally, parents also jeopardize their own children's lives because they seek a quack to cure their child's illness, not a medical authority. Arthritis, psychiatry, and mental retardedness are also areas that are prey to medical fraudulency. Even the smoking industry is not without its useless devices to help people quit the habit.

Medical quackery continues to abound for two reasons:

1. The ever increasing cost of good medical attention encourages people to look for cheap, easy cures. People are often fearful of the tremendous expense of a proper diagnosis and treatment. What they fail to realize is that early disease detection can often mean a simple, inexpensive treatment. The longer one postpones proper medical attention, the more difficult and, therefore, expensive the treatment of the disease becomes.

2. People become increasingly frustrated with unsuccessful methods of treatment and, consequently, vulnerable to methods which promise to alleviate their pain and suffering.

Advertisements for quick, weight-loss diets, cures for arthritis, miracle drugs, etc. can be found in almost any magazine, even respectable ones, and in the mail. The U.S. Postal Service has enforcement capabilities over mail fraud which includes medical quackery. If a person suspects an ad which has come in the mail is fraudulent, he can report it to the local postmaster or send it to the Postal Inspector's Service in Washington, D.C.

SIGNS OF MEDICAL QUACKERY

A person should suspect a person or product is fraudulent if:

1. A "quick cure" is guaranteed for a number of conditions, e.g. baldness, falling arches, dandruff, hallitosis, etc.

2. The method of treatment is a "secret" machine, drug or device. The quack often claims that the medical community would be "jealous" and take the wonder machine away if they knew about it.

3. The quack uses case histories or testamonials from famous people. There may well be some famous people who have also fallen prey to his "treatment". What he fails to tell people is that his cases have died shortly after making the testamonial.

4. The quack tells people that a biopsy or surgery would only "spread" the disease.

5. The quack generally holds no degrees, except perhaps, an honorary title. To be certain of a person's right to practice medicine in the state, check with the Medical Examining Board to be sure that he has a license. All physicians and others who practice medicine have to to pass a comprehensive medical licensing examination before they are allowed to practice.

6. The quack will ask you to sign a contract stating payment terms and other obligations.

7. The cure is too good to be true.

Remind your clients that the best method of treatment and cheapest in the long run, is by a well-trained, licensed physician who has an affiliation with an accredited hospital. He has been trained to care for the patient and will provide a method of treatment which is best for the patient and most cost effective.

TEACHING TECHNIQUE

GOAL: People will know how to detect medical quackery and how to avoid it.

OBJECTIVES: 1. To inform clients about medical quackery, where it appears, what it looks like and how to avoid it.
2. To inform clients about the best methods of treating illness.

STRATEGIES: Small Group Work

1. Collect advertisements about various health cures which appear to be fraudulent in nature. Discuss them with your clients. Ask them to share any experiences they may have had with medical fraud. Teach them the seven signs of medical quackery.
2. Write to the Postal Inspector's Office in

Washington, D.C. and ask for their free brochures on medical mail fraud. Make these available to your clients.

3. Show an audio-visual aid on health quackery and discuss its implications.

4. Invite a physician to speak to your clients on the importance of early disease detection. Provide hand-outs published by the various privately funded social service agencies which give information on early warning signs of disease.

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VIII SUMMARY

The type of health care one has and the amount of money he spends for it depends on a person's ability to shop wisely. A person can spend a great deal of money on health insurance, and, yet, not have good coverage. He can go to the most expensive fee-for-service doctor in the area and not get any better care than he would from a physician who practiced with an H.M.O. He can buy the most expensive brand name drug and not get better faster than he would have had he used the cheaper generic drug.

Buying health care needs planning, comparing and evaluating all of the options available. Does a person want a traditional fee-for-service physician? Does his health insurance cover routine visits or will he have to pay "out-of-pocket"? Would he prefer the options of an H.M.O.? If he can't afford the expenses of health insurance, would he be better off using hospital or county health department clinics?

To decide what health care package is best for him, each client will need to assess his needs, expectations, and financial situation. A person should choose the health care alternative that most comfortably fits him and his family.

After choosing the right physician, clinic, or H.M.O. for his needs, the person will need to know how to communicate with his physician. He will need to tell his physician about his life-style, his family background, aches and pains he may have had, or any unusual symptoms. A physician is not clairvoyant. He can only treat the patient for the symtoms that the patient

reveals. The patient will also need to ask why the doctor has chosen a particular method of treatment, how to carry through with that treatment and what unusual symptoms he should be on guard for that are related to the treatment. If a patient feels uncomfortable about a problem or treatment he should discuss it with his physician. The patient should also remember that he has the option of a second opinion from a different physician should he be uncertain about a prescribed treatment. Patients should also ask for generic drugs and quantity prescriptions whenever possible. If a patient has a billing dispute, he should call his physician and work out a resolution.

The patient becomes a consumer of health care; the product is his own well-being. Therefore, it behooves him to be a knowledgable consumer and an advocate of his rights.

***

APPENDIX

QUESTIONS TO ASK THE DOCTOR

BEFORE THE VISIT

1. What is the main reason for seeing the doctor?_____

   _____

2. What symptoms have I experienced that I should tell the doctor about?_____

   _____

3. What questions do I have to ask him about my medications, symptoms, physical condition?_____

   _____

DURING THE VISIT

1. Did the doctor check for the causes of my symptoms during the examination?_____
2. Did the doctor answer all my questions adequately?_____
3. What did the doctor say was wrong with me? (diagnosis) _____

   _____

4. What is the cause of my problem?_____

   _____

5. What is the proposed method of treatment?_____

   _____

6. Are there any precautions to remember about the medication (side-effects, effects when taken in conjunction with other drugs, etc.)?

   _____

7. Should any of my activities be changed or limited?_____

   _____

8. How may I avoid this problem in the future?_____

   _____

9. Should I return for another visit or call back with a progress report?_____

   _____

10. What were the results of any lab tests that the doctor made?_____

    _____

11. What will I need to do for any follow-up appointments? (refrain from eating, take medication, have tests completed, etc.) _____

    _____

12. Additional information_____

    _____

AMERICAN HOSPITAL ASSOCIATION
BILL OF RIGHTS

1. The patient has a right to considerate and respectful care.

2. The patient has a right to know by name the physician responsible for his care and to complete, current information of his diagnosis, treatment, and prognosis, explained in terms he can understand (through an interpreter, if necessary).

3. The patient has a right to all information necessary to give informed consent prior to the start of any procedure or treatment, including a full explanation of the various options that may exist and their consequences.

4. The patient has a right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential. Persons not directly involved in his care must have his permission to be present.

6. All communications and records pertaining to the patient's care should be treated as confidential, and he has a right to know what will be done with his records and who will have access to them.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services, and the hospital must provide evaluation, service and/or referral as indicated by the urgency of the case. No hospital may refuse to deal with an emergency, even if the hospital considers its facilities inappropriate to the patient. It must do what it can and arrange a referral.

8. A patient must be informed of any hospital relationships with other health care or educational institutions insofar as his care is concerned.

9. The patient has a right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment, and he has a right to refuse to participate in such research projects. This includes the use of new drugs being evaluated prior to FDA approval and new surgical procedures.

10. The patient has a right to expect reasonable continuity of care and to know that the hospital will arrange for and inform him of continuing health care requirements following discharge.

11. The patient has the right to examine and receive explanation of his bill regardless of the source of payment.

12. The patient has the right to know what hospital rules apply to his conduct.

PATIENT'S BILL OF RIGHTS
IN A NURSING HOME

A "bill of rights" requires that each patient admitted to a nursing home:

1. Is fully informed, as evidenced by the patient's written acknowledgement, prior to or at the time of admission and during his stay, of his rights and of all rules and regulations governing patient conduct and responsibilities.

2. Is fully informed, prior to or at the time of admission and during his stay, of services available in the facility, and or related charges including any charges for services not covered under Titles XVIII or XIX of a facility's basic per diem rate.

3. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented by a physician in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research.

4. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for non-payment for his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to insure orderly transfer or discharge, and such actions are documented in his medical record.

5. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal.

6. May manage his personal financial affairs, or may have access to records of financial transactions made on his behalf at least once a month and is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law.

7. Is free from mental and physical abuse, and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified period of time, or when necessary to protect the patient from injury to himself or to others.

8. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except in case of his transfer to another health care institution, or as required by law or third-party payment contract.

9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.

PATIENT'S BILL OF RIGHTS IN A NURSING HOME *(continued)*

10. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care.

11. May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record).

12. May meet with, and participate in, activities of social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record).

13. May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record), and

14. If married, is assured privacy for visits by his or her spouse; if both are patients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).*

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* Department of Health, Education, and Welfare, Social Security Administration, Skilled Nursing Facilities, Health Insurance for the Aged and Disabled; General Administration, Federal Register, October 3, 1974, Vol. 39, No. 193, pp. 35775 - 35778.

TWENTY QUESTIONS FOR EVALUATING A NURSING HOME*

	NURSING HOME A	B	C
1. Does the nursing home have a current state and federal license?			
2. Is the administrator licensed under state law?			
3. Is the home neat and clean and free of bad odors?			
4. Is the home designed for elderly and disabled residents? Is it well-lighted with many safety features (grab bars, non-slip floors, ramps, call buttons, etc.)			
5. Are there activities for the residents?			
6. Is the staff friendly and helpful?			
7. What services are provided by the home? Physical therapy Occupational therapy Speech therapy Reality Orientation Inhalation therapy Respiratory therapy			
8. Are the services mentioned above included in the basic charge?			
9. Is the nursing home certified to participate in Medicare, Medicaid, or other state and local welfare programs?			
10. Can the person keep his physician and will he be easy to reach?			
11. Does the contract between the resident and the home clearly state the: date of admission level of care services that will be provided discharge or transfer conditions			
12. Is the home close to family and friends? Are stores, churches, etc. close by?			
13. Is it easy to visit the patient?			
14. Is the patient's privacy respected?			
15. Are the residents allowed to bring their own things? Are their things listed when they are admitted to the home?			
16. Are residents friendly and do they talk to one another?			
17. Does the food look and taste good?			
18. Can the resident have a special diet if he needs it?			
19. Is the home air-conditioned?			
20. Does the home meet all the building and fire codes?			

*For a more comprehensive checklist consult the Area Agency on Aging's "Guide to Nursing Homes" or the National Retired Teacher's Association brochure, "Selecting a Nursing Home".

PRIVATELY FUNDED
SOCIAL SERVICE AGENCIES

AGENCY AND SERVICES PROVIDED	TELEPHONE NUMBERS RICHMOND	NO. VIRGINIA
American Cancer Society	804-359-0208	703-938-5550
Loan closet		
Financial aid for medications		
Counseling Services		
Ostomy Club		
New Voice Club		
Reach-to-Recovery		
Make Each Day Count		
Some home health care provided		
Volunteer transportation to doctor and treatment centers.		
Educational materials		
American Heart Association	804-353-9583	703-941-8500
Referrals for financial assistance		
Educational materials		
American Diabetes Association	804-353-3527	703-657-8303
Syringes		
Money for purchase of emergency insulin		
Free education and nutrition classes		
Registered nurse and dietician on call to answer questions about the disease.		
American Kidney Foundation	TOLL FREE 800-638-8299	
Financial assistance		
Balance not paid by Medicare for home supplies		
Medications		
Transportation		
Maintenance grants to pay fuel costs or special diets		
Educational materials		
American Lung Association	804-355-3295	703-591-4131
Main purpose is to offer support to sufferers of chronic lung diseases and education on prevention		
Loan closet		
Financial assistance		
$240 per patient year for oxygen		
Courses and workshops for sufferers of chronic lung disease and asthma		

AGENCY AND SERVICES PROVIDED	TELEPHONE NUMBERS RICHMOND	NO. VIRGINIA
American Arthritis Foundation Membership fee of $15.00/ year 10% reduction on all medications Some financial assistance for wheelchairs Educational programs	804-282-5491	703-331-7395
Cystic Fibrosis Four clinics: Charlottesville, Richmond, Norfolk, and Washington, D.C. offer counseling and referral	804-649-1352	202-296-2882
Lions Eye Bank and Research Foundation Sight conservation and sight restoration provide eyeglasses for indigent funds for corneal transplant or temporal bone transplant Donor banks	804-264-2044	703-765-4524
Leukemia Society Patient aid transportation to clinics cover chemotherapy drugs not covered by insurance up to $600/patient year Education	804-643-7333	202-223-2656
Multiple Sclerosis Exercise classes Friendship line Newsletter Counseling Vocational Rehabilitation for reemployment	804-353-6631	202-296-5363
Muscular Dystrophy Clinics Loan closet orthopedic equipment, beds, chairs, etc. to aid daily living Recreation programs Transportation Education	804-358-7131	703-466-7450
American Red Cross Transportation for low-income people to medical appointments Blood Banks Educational programs on health maintenance	804-643-7451	703-737-8300
United Cerebral Palsy Therapy on sliding fee scale Coordination of services Infant programs and pre-school programs Orthopedic consultation Transportation and referral	804-359-0359	703-534-5353

COMPARING HEALTH INSURANCE POLICIES

ITEMS FOR COMPARISON	COMPANY A	COMPANY B	COMPANY C
THE INSURANCE COMPANY			
PROMPTNESS OF PROCESSING CLAIMS			
THE POLICY			
BASIC PROTECTION			
COVERED SERVICES			
NON-COVERED SERVICES			
PAYMENT SCHEDULE			
MAJOR MEDICAL			
DEDUCTIBLE			
CO-PAYMENTS			
DISABILITY			
GROUP OR INDIVIDUAL			
IF GROUP,... CONVERTIBLE TO INDIVIDUAL POLICY			
SPECIFIC SUPPLEMENTS AVAILABLE IF NECESSARY			
THE TOTAL COST			
ANNUAL PREMIUM			
QUARTERLY PREMIUM			
MONTHLY PREMIUM			

MEDICARE/SUPPLEMENTAL INSURANCE CHECKLIST

NOT COVERED BY MEDICARE *(1980 figures; figures subject to change in 1981)*	COVERED BY PROPOSED POLICY? YES	NO	POLICY PAYMENT
$207 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible).			
$45 a day for the 61st to 90th day of inpatient hospital services in a benefit period.			
$90 a day for inpatient hospital services for each "lifetime reserve" day used (can be used up to a total of 60 days in your lifetime, whenever you need more than 90 days in a benefit period).			
Over 150 days of inpatient hospital services in a benefit period (over 90 days if you have used all your "lifetime reserve" days).			
$22.50 a day for the 21st day to 100th day in a benefit period for inpatient services in a skilled nursing facility.			
Over 100 days of inpatient skilled nursing facility care in a benefit period.			
Nursing home care in other than a skilled nursing facility (except when medically necessary).			
Private room in a hospital or skilled nursing facility (except when medically necessary).			
Over 100 home health visits for each benefit period under Medicare hospital insurance.			
The first three pints of blood under either medicare hospital or medical insurance.			
The first $60 of doctor bills and other medical insurance (the medical insurance annual deductible).			

NOT COVERED BY MEDICARE	COVERED BY PROPOSED POLICY YES	NO	POLICY PAYMENT
After the first $60, 20% of "reasonable charges" for doctor bills and other bills for covered medical services and supplies under Medicare medical insurance			
Charges above the Medicare "reasonable charge" in non-assignment cases.			
Drugs and medicines you buy yourself			
Eyeglasses (except after cataract surgery)			
Hearing aids			
Dental care			
Medical care outside the United States			

Are there any additional benefits the proposed policy pays? Yes____ No____
If yes, describe._____

_____

_____

a. Is there a preexisting condition exclusion? Yes____No____
If yes, what conditions are excluded and for how long?_____

_____

_____

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57 b. Is there a waiting period before policy pays benefits? Yes____ No____
If yes, when does the policy begin paying benefits?_____

Reprinted from Medicare and Private Health Insurance, A Training Text, U.S. Department of Health and Human Services, Health Care Financing Administration, (HCFA) 80-01 001.

AGENCIES TO CONTACT FOR ADDITIONAL ASSISTANCE WITH HEALTH CARE PLANNING

HEALTH SYSTEMS AGENCIES OF VIRGINIA

Central Virginia HSA, 2015 Staples Mill Road, #419, Richmond, Virginia 23230

Eastern Virginia HSA, 11 Koger Executive Center, #203, Norfolk, Virginia 23502

Northern Virginia HSA, 7245 Arlington Blvd., Suite #300, Falls Church, Virginia 22042

Northwestern Virginia HSA, 2015 Ivy Rd., Suite 314, Charlottesville, VA 22903

Southwest Virginia HSA, 200 South Country Club Drive, Blacksburg, Virginia 24060

VIRGINIA DEPARTMENT OF HEALTH.....804-786-1668
109 Governor Street
James Madison Building
Richmond, Virginia 23219

DEPARTMENT OF HEALTH REGULATORY BOARDS.....804-257-0345
3600 W. Broad Street
453 Seaboard Building
Richmond, Virginia 23230

AREA AGENCY ON AGING
Virginia Office on Aging.....804-786-7894
830 E. Main Street
Suite 950
Richmond, VA 23219

VIRGINIA OFFICE OF CONSUMER AFFAIRS
3016 Willaims Drive
Fairfax, Virginia 22031.....703-573-1286
or
Box 1163
Richmond, Virginia 23219.....800-552-9963
(Toll Free)

UNITED STATES POSTAL INSPECTION SERVICE
P.O. Box 1820
Washington, D.C. 20013.....202-523-2561

Related Materials Available on a Free Loan Basis From The Virginia Office of Consumer Affairs

Title	Topic
"Buying Health Care" *filmstrip/cassette*	Shopping for a doctor, hospital and prescriptions
"Consumer Skills: Shopping for Health Care" *filmstrip/cassette*	Overview of health care facilities; choosing a doctor, hospital and insurance
"Health Quackery" *slide/cassette tape*	Kinds of Health Quackery *captioned for deaf and Spanish audiences*
"Medicare/Medicaid" *videocassette*	Programs and services
"Over the Counter Pills and Promises" *16 mm film*	Problems related to buying non-prescription drugs
"Planning for Health Care and Health Care Costs" *slides/cassette tape*	Tips on health care concerns
"Practical Drug Series" *filmstrip/cassette*	How to choose a pharmacy and the proper use of drugs
"Prescription Drugs: Rx for Savings *slides/cassette tape*	Shopping for medications, questions to ask the physician *captioned for deaf and Spanish audiences*
"The Assertive Consumer: Health" *videocassette*	*made for Vietnamese audiences*

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